City of San Jose
Group# 975567, 975571
Custom PPO℠ 90/70

Benefit Summary (For groups of 300 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Effective January 1, 2011

	Preferred Providers[2]	Non-Preferred Providers[2]
Calendar year Medical Deductible[1] (All providers combined)	$100 per individual/$200 per family	
Calendar year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$2,000 per individual/$4,000 per family	
LIFETIME BENEFITMAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[2]**	**Non-Preferred Providers[2]**
Professional (physician) benefits		
• Physician and specialist office visits	$10 per visit (Not subject to the Calendar-Year Deductible)	30%
• Diagnostic testing	10%	30%
• Outpatient X-ray, pathology and laboratory	10%	30%
Allergy testing and treatment benefits		
• Office visits (includes visits for allergy serum injections)	$10 per visit	30%
Preventive health benefits		
• Annual routine physical examination office visit: including the physical examination office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent.	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Annual routine gynecological office visit: including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test ,human papillomavirus (HPV) screening tests (One per calendar year)	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Routine laboratory services, including well baby laboratory services	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Well baby office visit: including well baby examination office visit, pediatric immunizations and the immunization agent, well baby vision and hearing screening	No charge (Not subject to the Calendar-Year Deductible)	Not covered
OUTPATIENT SERVICES		
Hospital benefits (facility services)		
The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $600 per day. Members are responsible for 30% of this $600 per day, plus all charges in excess of $600.		
• Outpatient surgery performed in an ambulatory surgery center[3]	10%	30%
• Outpatient surgery in a hospital	10%	30%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	10%	30%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	10%	30%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services)		
• Inpatient physician benefits	10%	30%
• Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies)	10%	30%[4]
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	10%	30%[4]

Skilled nursing facility benefits[6] (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Services by a free-standing skilled nursing facility	10%	10% with prior authorization[6]
• Skilled nursing facility unit of a hospital	10%	30%[4]
EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$50 per visit	$50 per visit
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician services	10%	10%
AMBULANCE SERVICES		
• Emergency or authorized transport	10%	10%
PRESCRIPTION DRUG COVERAGE **Outpatient prescription drug benefits**	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Services.	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	10%	30%
• Orthotic equipment and devices (Separate office visit copay may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	**MHSA Participating Providers**[2]	**MHSA Non-Participating Providers**[2]
• Inpatient hospital services	10%	30%[4]
• Outpatient mental health services	$10 per visit (Not subject to the Calendar-Year Deductible)	30%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10] **Please see footnote 9**		
• Chemical dependency and substance abuse services	Not covered	Not covered
HOME HEALTH SERVICES[11]	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	10%	Not covered[11]
• Home infusion/Home injectable therapy provided by a home infusion agency (See "Prescription Drug Coverage" for home self-administered injectables.)	10%	Not covered[11]
OTHER **Hospice program benefits**[11]		
• Routine home care	No charge	Not covered[11]
• Inpatient respite care	No charge	Not covered[11]
• 24-hour continuous home care	10%	Not covered[11]
• General inpatient care	10%	Not covered[11]
Chiropractic benefits[8]		
• Chiropractic services – provided by a chiropractor (Up to 20 visits per calendar year)	10%	30%
Acupuncture benefits[8]		
• Acupuncture (Up to 20 visits per calendar year)	10%	10%
Rehabilitation benefits (physical, occupational and respiratory therapy)		
• Office location	10%	30%
Speech therapy benefits		
• Office location	10%	30%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	10%	30%

Family planning benefits		
• Counseling and consulting	$10 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion[12]	10%	Not covered
• Tubal ligation[12]	10%	Not covered
• Vasectomy[12]	10%	Not covered
Diabetes care benefits		
• Devices, equipment, and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Benefits.")	10%	30%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$10 per visit	30%
Care Outside of Plan Service Area Benefits provided through BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

Optional Benefits Optional dental, vision, substance abuse treatment, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage, and the Plan Contract for exact terms and conditions of coverage.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 30 percent of this $600 per day, plus all charges in excess of $600.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further benefit details.

6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

7 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage or plan contract.

8 All outpatient acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

9 **Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**

10 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

11 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements

A17265 (10/10) RO 093010